(1) The total amount of actual operating expenses of the residence (utilities, maintenance, furnishings, appliances, service equipment, all other operating costs) for the previous fiscal year plus 15 percent of that amount equals the total operating budget for the current fiscal year. The total operating budget is to be divided by the average number of beds occupied during the previous fiscal year and the resulting amount is the average yearly amount per bed. The bi-weekly fee shall equal 1/26th of the average yearly amount per bed, except that a resident shall not, on average, pay more than 30 percent of their gross CWT (Compensated Work Therapy) bi-weekly earnings. The VA program manager shall, bi-annually, conduct a review of the factors in this paragraph for determining resident payments. If he or she determines that the payments are too high or too low by more than 5 percent of the total operating budget, he or she shall recalculate resident payments under the criteria set forth in this paragraph, except that the calculations shall be based on the current fiscal year (actual amounts for the elapsed portion and projected amounts for the remainder).

(2) If the revenues of a residence do not meet the expenses of the residence resulting in an inability to pay actual operating expenses, the medical center of jurisdiction shall provide the funds necessary to return the residence to fiscal solvency in accordance with the provisions of this section.

(e) The length of stay in housing under the Compensated Work Therapy/Transitional Residences program is based on the individual needs of each resident, as determined by consensus of the resident and his/her VA Clinical Treatment team. However, the length of stay should not exceed 12 months.

(Authority: 38 U.S.C. 1772)

[70 FR 29627, May 24, 2005]

§ 17.49 Priorities for outpatient medical services and inpatient hospital care.

In scheduling appointments for outpatient medical services and admissions for inpatient hospital care, the Under Secretary for Health shall give priority to:

(a) Veterans with service-connected disabilities rated 50 percent or greater based on one or more disabilities or unemployability; and

(b) Veterans needing care for a service-connected disability.

(Authority: 38 U.S.C. 101, 501, 1705, 1710)

[67 FR 58529, Sept. 17, 2002]

USE OF DEPARTMENT OF DEFENSE, PUBLIC HEALTH SERVICE OR OTHER FEDERAL HOSPITALS

§ 17.50 Use of Department of Defense, Public Health Service or other Federal hospitals with beds allocated to the Department of Veterans Affairs.

Hospital facilities operated by the Department of Defense or the Public Health Service (or any other agency of the United States Government) may be used for the care of Department of Veterans Affairs patients pursuant to agreements between the Department of Veterans Affairs and the department or agency operating the facility. When such an agreement has been entered into and a bed allocation for Department of Veterans Affairs patients has been provided for in a specific hospital covered by the agreement, care may be authorized within the bed allocation for any veteran eligible under 38 U.S.C. 1710 or 38 CFR 17.44. Care in a Federal facility not operated by the Department of Veterans Affairs, however, shall not be authorized for any military retiree whose sole basis for eligibility is under §17.46b, or, except in Alaska and Hawaii, for any retiree of the uniformed services suffering from a chronic disability whose entitlement is under §17.46b, §17.47(b)(2) or §17.47(c)(2) regardless of whether he or she may have dual eligibility under other provisions of §17.47.

[39 FR 1842, Jan. 15, 1974, as amended at 45 FR 6936, Jan. 31, 1980, as amended at 61 FR 21966, May 13, 1996]

§ 17.51 Emergency use of Department of Defense, Public Health Service or other Federal hospitals.

Hospital care in facilities operated by the Department of Defense or the Public Health Service (or any other agency of the U.S. Government) which do not have beds allocated for the care

of Department of Veterans Affairs patients may be authorized subject to the limitations enumerated in §17.50 only in emergency circumstances for any veteran otherwise eligible for hospital care under 38 U.S.C. 1710 or 38 CFR 17.46.

[33 FR 19010, Dec. 20, 1968. Redesignated and amended at 61 FR 21965, 21966, May 13, 1996]

USE OF PUBLIC OR PRIVATE HOSPITALS

§ 17.52 Hospital care and medical services in non-VA facilities.

(a) When VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required, VA may contract with non-VA facilities for care in accordance with the provisions of this section. When demand is only for infrequent use, individual authorizations may be used. Care in public or private facilities, however, subject to the provisions of §17.53 through f, will only be authorized, whether under a contract or an individual authorization, for

(1) Hospital care or medical services to a veteran for the treatment of—

(i) A service-connected disability; or

(ii) A disability for which a veteran was discharged or released from the active military, naval, or air service or

(iii) A disability of a veteran who has a total disability permanent in nature from a service-connected disability, or

(iv) For a disability associated with and held to be aggravating a service-connected disability, or

(v) For any disability of a veteran participating in a rehabilitation program under 38 U.S.C. ch. 31 and when there is a need for hospital care or medical services for any of the reasons enumerated in §17.48(j).

(Authority: 38 U.S.C. 1703, 3104; sec. 101, Pub. L. 96–466; sec. 19012, Pub. L. 99–272)

(2) Medical services for the treatment of any disability of—

(i) A veteran who has a service-connected disability rated at 50 percent or more,

(ii) A veteran who has received VA inpatient care for treatment of non-service-connected conditions for which treatment was begun during the period of inpatient care. The treatment period (to include care furnished in both facilities of VA and non-VA facilities or any combination of such modes of care) may not continue for a period exceeding 12 months following discharge from the hospital except when it is determined that a longer period is required by virtue of the disabilities being treated, and

(iii) A veteran of the Mexican border period or World War I or who is in receipt of increased pension or additional compensation based on the need for aid and attendance or housebound benefits when it has been determined based on an examination by a physician employed by VA (or, in areas where no such physician is available, by a physician carrying out such function under a contract or fee arrangement), that the medical condition of such veteran precludes appropriate treatment in VA facilities;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(3) Hospital care or medical services for the treatment of medical emergencies which pose a serious threat to the life or health of a veteran receiving hospital care or medical services in a facility over which the Secretary has direct jurisdiction or government facility with which the Secretary contracts, and for which the facility is not staffed or equipped to perform, and transfer to a public or private hospital which has the necessary staff or equipment is the only feasible means of providing the necessary treatment, until such time following the furnishing of care in the non-VA facility as the veteran can be safely transferred to a VA facility;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(4) Hospital care for women veterans;

(Authority: 38 U.S.C. 1703; sec. 19012, Pub. L. 99–272)

(5) Through September 30, 1988, hospital care or medical services that will obviate the need for hospital admission for veterans in the Commonwealth of